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Expanding the Net
Building Mental Health Care Capacity for Veterans

POLICY BRIEF

By Phillip Carter

Of the nation's 22 million veterans, only a minority (roughly 6 million) seek care or benefits from the Department of Veterans Affairs (VA). However, of those who do, a plurality seek care for a variety of mental health issues, ranging from post-traumatic stress disorder (PTSD)[1] to the cognitive effects of traumatic brain injury (TBI) to mental health issues associated with the transition from military to civilian life. The VA will spend approximately $7 billion this year to meet this need, serving veterans through its expansive network comprising more than 150 hospitals, 800 community clinics and thousands of clinicians. However, these resources do not fully meet the needs of veterans seeking mental health care across the nation.

Historically, veterans' mental health care needs have risen sharply over time, with peak expenditures occurring 10 to 20 years after the end of war. This was true for the Vietnam War cohort and will likely be true for the post-9/11 combat cohort as well.[2] Now is the time for the VA to act decisively to meet these generations' needs – while it has ample resources to do so, before the demand among post-9/11 veterans spikes. There have been several major steps in this direction, including the hiring of 1,600 additional clinicians and the announcement in September of $9 billion in contract awards for the VA's new Patient-Centered Community Care (PCCC) initiative. These steps will greatly expand the VA's capacity to meet current need but will likely not be enough for future demand, based on current veterans data and the projections of leading veterans organizations.[3]

This paper provides background on the current mental health needs of veterans[4] and outlines several approaches for the VA to adopt (or embrace more fully) to generate additional mental health care capacity. Given the enormous breadth and diversity of veterans' mental health care needs, this policy brief argues for a portfolio approach that will invest in a few of the most promising models to generate that capacity. This policy brief also recommends that more attention be paid to integrating these approaches, including efforts to link care provided by the VA with care provided in the private and non-profit sectors.

Background

In 2012, the VA cared for nearly 6 million of the nation's 22 million veterans, including 83.6 million outpatient visits and roughly 703,500 inpatient admissions.[5] Much of this care focused on mental

health problems, including PTSD and TBI. As of July 2013, there were approximately 2.6 million veterans of Iraq, Afghanistan and other theaters of the global war on terrorism.[6] The leading study in the field estimated that roughly 15 to 20 percent of these new combat veterans would come home with symptoms of PTSD or TBI (with significant overlap between these populations).[7] To date, nearly 900,000 Iraq and Afghanistan veterans have sought VA care, and 54 percent (486,015) of them have been diagnosed with a mental health disorder of some type.[8]

In addition to heavily utilizing VA health care resources, today's veterans are also filing claims for disability compensation at record levels. Nearly half of Iraq and Afghanistan veterans have filed claims with the VA, with each claiming eight to nine disabling issues on average. As of October 28, 2013, there were 711,775 claims pending with the VA for compensation or pension benefits, down from a high of 903,286 in March 2013,[9] with 57 percent of the current claims pending for more than the VA's target of 125 days. A majority of these pending claims contain disability contentions relating to mental health, including post-traumatic stress resulting from combat.

The most severe manifestation of the mental health need in the veterans community can be seen in the numbers of suicides within this group. The best data on the subject, from a recent study by the VA's mental health research team, estimates that 22 veterans die by suicide each day.[10] Most did not serve in combat, and it is unclear how many of these suicides result from the stresses of military service or from some other factors in the veterans' lives. However, the data strongly suggest that VA mental health outreach and care reduces suicide. This evidence extends to lesser manifestations of mental health care need as well. According to one recent survey, "Experts note that timely, early

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[mental health care] intervention services can improve veterans' quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems."[11]

Unfortunately, despite this evidence, the VA has failed to meet demand for such care. In December 2012, the Government Accountability Office concluded that outpatient medical appointment wait times reported by the VA were "unreliable," and that scheduling problems impeded access to care and adversely affected patient satisfaction.[12] One recent survey reported that 91.3 percent of VA physicians agreed with the statement that "veteran patients experience delays in care as a result of the VA's process of scheduling visits."[13] A RAND report echoed this finding, stating that most physicians who do not work for the Veterans Health Administration (VHA) "report difficulties accessing the appropriate level of care for their patients within the VHA system and feel that patients experience care delays, unclear roles and responsibilities, and lack of management plans for patients who use both systems."[14] The VA also struggles to retain veterans once they make it through the doors, with retention rates for veterans in many treatment programs often falling below 50 percent.[15]

The demand for additional mental health care resources for veterans is clear. The VA has begun addressing the shortfall by hiring more clinicians, using contractors and other means described below.

However, clinical appointment wait times remain long, and these approaches are not yet fully meeting demand, let alone building excess capacity to meet projected future demands. The remainder of this policy brief describes how the VA can improve the situation by adopting a portfolio of approaches to delivering mental health care, and improving its infrustructure as well.

Models for Expanding Capacity

CURRENT MODEL (VA CARE WITH MOSTLY VA PERSONNEL)

The VA provides the majority of its healthcare to veterans via 151 VA medical centers and more than 800 community-based outpatient clinics – the largest integrated healthcare system in the country. These hospitals and clinics provide care to those eligible veterans who are enrolled with the VA and able to access care based on where they fall within the VA's priority group schema. The VHA relies primarily on VA employees to provide this care, giving it the largest workforce in government outside of the Department of Defense. The VA also provides mental health care through its network of nearly 400 Vet Centers and mobile Vet Centers, which are run by a separate arm of the VA, the Readjustment Counseling Service.

This model differs from other agencies' operations in a few important respects. First, instead of procuring medical services from the private sector via grants or reimbursements (in the way that Medicaid and Medicare operate), the VA provides 90 percent of its care directly. Second, the VA does not rely on a large contractor workforce, unlike many other agencies that outsourced significant parts of their operations during the past two decades. And third, the VA operates alongside other care options, with little coordination or information-sharing between the VA and the non-VA health care providers that provide the majority of care for veterans.

There are three main ways to increase capacity within the VA health care system: hire more clinicians, extend utilization of existing facilities (such as by increasing hours, or deploying new delivery models or care approaches) or open new facilities. The VA recently announced the completion of its drive to hire 1,600 additional mental health care providers, including psychiatrists, psychologists and social workers. In addition, the VA has launched pilot efforts around the country to expand its hours. These efforts have the major advantage of being fully integrated with the VA's health care network, including patient record integration. This model also allows the VA to expand its capacity within existing budgetary, human capital and facility structures. However, this model offers limited scalability because of the finite capacity of internal VA systems, difficulties in hiring clinicians, practical limits on facility capacity, and high cost and friction associated with opening and closing facilities to meet changing demand.

CURRENT MODEL + (VA CARE WITH STAFF AUGMENTATION)

The VA currently surges its capacity by contracting with private firms to add clinical and support staff. This model mirrors existing arrangements across the federal government for staff augmentation. These personnel work for their respective private firms, drawing pay and benefits from those companies. However, they integrate fully into the VA workforce, working for VA supervisory personnel (for purposes of providing mental health care) inside VA facilities.

This model addresses a significant shortfall in the VA's existing business model: its ability to rapidly scale and adapt its workforce to meet changes in demand. As noted above, the VHA workforce is composed primarily of U.S. government employees. They serve within the existing VHA personnel system and are tied to existing VHA facilities. Changes to the size, composition or location of this workforce require the VA to overcome significant

friction, including collective bargaining agreements, internal VA regulations, differential costs of living and other factors. The contractor augmentee model sidesteps these challenges by leveraging a private sector workforce outside of the VA's existing human capital systems. Unfortunately, most of this type of capacity generation is now done on a piecemeal basis, at a very local level, a few providers at a time. There is no national effort to reap economies of scale from this augmentation, nor a national effort to ensure consistency or quality of care at a Veterans Integrated Service Network (VISN) or national level.

Further, contractor augmentation provides the scalability that the VA human capital system lacks. This model can accommodate both growth, as has happened in recent years, and shrinkage, a possibility in the future as the number of veterans declines. Although short-term costs may be higher for a contractor-augmented workforce, long-term costs will likely be lower because of this scalability and associated savings in benefit and retirement expenses. Contractor staff augmentation carries some perceived risk with respect to provider quality and competency. However, this risk has been addressed by DOD and the VA by hiring contractors with some military experience or cultural competency.

CURRENT MODEL ++ (VA CARE PLUS CONTRACTED NETWORKS)

A related, more expansive model for generating capacity involves using private firms to build, operate and manage projects, clinics or whole divisions of operations. Federal agencies frequently use this approach to procure information technology (IT) services, as well as to procure large systems or conduct major development and foreign assistance abroad. At DOD, this model has been used to procure TRICARE networks and other health care and family support services. The VA uses this model to operate community-based outpatient clinics (CBOCs) and also to procure IT services and support, among other things. However, the VA has not fully embraced this model, in part because of concerns that it might replace its "brick and mortar" facilities with non-VA providers and networks, reducing the overall national commitment to care for veterans.

The CBOC program represents the largest VA effort to generate additional care capacity through contracting networks. Approximately 25 percent of CBOCs nationwide are managed on a contract basis for the VA, with the remainder owned and operated by the VA or operated by VA personnel in leased space. Contracted CBOCs must meet the VA's standards and those of the Joint Commission,[16] and also must work within the VA health care system including the VA's prescription drug formulary, its appointment system and medical records system. The VA generally pays its CBOC contractors a monthly rate for each veteran enrolled in that clinic, for a package that typically includes primary care and mental health care, but the specific package of services varies significantly from clinic to clinic based on patient population, clinic capabilities and other factors.[17] Evidence gathered by the VA, Congressional auditors and independent researchers suggests that CBOCs cost the government significantly less than VA medical centers, and produce comparable (or better) patient outcomes and patient satisfaction.[18]

A related model will be available in the VA's new Patient-Centered Community Care initiative, for which it recently awarded two contracts which may be worth up to $9 billion over five years. According to the contract announcement, the VA plans to use this program to purchase "inpatient and outpatient specialty care and mental health care for eligible Veterans when the local VA Medical Center (VAMC) cannot readily provide the services, such

as when there is a lack of available specialists, there are long wait times, or there is an extraordinary distance from the Veteran's home."[19] In addition to medical care and mental health care, the PCCC initiative will allow the VA to purchase medical equipment, home nursing and therapy, and other services for veterans.

The PCCC program builds on earlier VA efforts (such as Project HERO, which ran from 2007 to 2012) to develop more capacity in the private sector to serve veterans. Of all of the approaches in the portfolio, the PCCC program holds the most promise, because of its potential for scalability and expansion, and the extent to which the PCCC networks will be integrated into the VA's health care system, ensuring continuity of care. However, in order to reap these rewards, the VA will need to invest more in the PCCC program than it has in past programs. And in doing so, the VA must ensure the seamless integration of the PCCC provider networks into the broader VA healthcare system, including the VA's electronic health records and appointment systems.[20] The VA must also leverage the built-in PCCC contract provisions relating to training, personnel qualifications, and quality assurance, to ensure that its two implementing partners meet expectations for care under this model. The VA selected two companies (TriWest Healthcare Alliance and Health Net Federal Services) with experience managing care for veterans and military personnel, a decision that should mitigate the historical concerns of veterans groups regarding approaches such as PCCC.[21]

LOCAL PARTNERSHIPS

In addition to generating its own capacity, the VA has turned increasingly to private sector and nonprofit partners to provide additional resources to serve veterans. In general, these models rely on the VA's legal authorities to enter into contracts for health care services or to reimburse private providers directly for the health care services they provide to eligible veterans. In theory, this category includes every arrangement from an individual reimbursement transaction to a strategic partnership with a regional health care organization. This policy brief focuses on two partnership models that have gained attention in recent months because of their success or broad utilization: the VA's partnership with North Shore-Long Island Jewish (LIJ) Health System and the collaboration between the VA and Federally Qualified Health Centers (FQHCs).

In 2012, North Shore-LIJ and the VA Medical Center at Northport developed a system of collaborative care for veterans and their families.[22] The system, funded by philanthropic investments and public dollars, enables both veterans and their families to be seen at the same facility, even though the populations technically fall under the separate coverage of the VA and LIJ systems respectively. Furthermore, the partnership enabled "cross talk" between civilian and VA mental health care providers, leveraging the experience of both. The system targeted measurable outcomes in a number of areas, to include impact on the veteran, the caregiver and service providers. The model is still being developed, refined and evaluated by North Shore-LIJ and the VA. If the program proves successful, it may be able to be replicated in other locations, with some variations to reflect the local partners available across the country. This model offers unique possibilities because of the ways it blurs lines between public and private facilities and providers, leveraging the resources of the VA to bolster the care capacity of existing private sector and nonprofit sector care providers and networks.

The VA also works with FQHCs – outpatient clinics funded by other federal agencies to provide medical services to underserved communities in rural and urban areas. The VA already works with

more than 50 FQHCs across the country to serve veterans in a variety of areas, leveraging a mix of contracting and funding mechanisms to pay for veterans' health care at these non-VA centers.[23] This model offers enormous potential for the VA because it leverages existing health centers with a footprint in already underserved communities (where veterans are also underserved). However, as with other private sector and nonprofit providers, these centers do not integrate into the VA system, which limits the continuity of care they can provide to veterans. Similarly, the same quality and cultural competency issues exist for these providers in other non-VA facilities. However, these may be mitigated somewhat by the high numbers of veterans who use some FQHCs in underserved areas with high concentrations of veterans, and could be further mitigated by additional VA requirements that condition the receipt of funding on meeting specified quality or competency goals for care given to veterans.

PRIVATE PHILANTHROPY

Yet another approach involves deploying philanthropic funds and private sector resources to provide mental health care to veterans. Although these do not offer the same ability for the VA to generate more capacity as the models described above, non-profit organizations do hold a great deal of promise, particularly for filling gaps in VA care, such as to underserved populations or populations not eligible for VA care (such as those veterans with other than honorable discharges).

Tens of thousands of non-profit organizations serve veterans across the nation, with many providing mental health services of some type. Among these, four models stand out as particularly prominent, either because of their national reach, reputation or potential for expansion. The first is the Welcome Back Veterans initiative, which started in 2008 and has matured into a partnership between the

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McCormick Foundation, Major League Baseball, and a number of academic medical centers including UCLA, the University of Michigan, Massachusetts General and others. Each medical center's program operates differently, based on the needs of veterans in that community, the VA's activities and the center's capabilities. In addition to mental health counseling, the programs include outreach and peer support models, training for clinical providers, wellness workshops for reservists, parenting workshops, family therapy and research trials for new PTSD treatment approaches. The program also includes a small evaluative component, under the auspices of the RAND Corporation.

Another prominent example is Give an Hour, an organization founded in 2005 by a Washington-area psychologist. Give an Hour manages a network of nearly 7,000 mental health care providers around the country who have agreed to provide an hour of therapy each week to veterans seeking mental health services. Give an Hour also provides varying degrees of connectivity between community-based organizations, practitioners and veterans (among others), as well as training and support.

Another organization, the Tragedy Assistance Program for Survivors (TAPS), is a nonprofit organization that provides peer-based support to survivors of the fallen, including parents, spouses, children and other loved ones. TAPS provides a national peer mentor program, connections to grief support services, the National Military Survivor

Helpline and case work assistance for surviving family members, as well as connections to other organizations (including the VA). TAPS provides these services at no cost, and does not receive government funding. However, the TAPS model could potentially be leveraged by the VA to expand the capacity of its mental health net, through similar peer-based support models or by providing other types of assistance.

A fourth model is represented by a Wounded Warrior Project (WWP) initiative. After hearing reports that wounded warriors were waiting a long time for VA mental health care appointments, WWP worked with private insurance companies to expand Employee Assistance Programs to give veterans timely access to mental health care. In funding this initiative, WWP was able to leverage existing networks of mental health care providers and facilities. This effort does not build new mental health care capacity as much as it complements existing mental health services by providing a continuum of other services and support funded through WWP, making those available to WWP's target population of veterans wounded, injured or ill in service after 9/11 (as well as their families).[24]

Each of these philanthropic models has demonstrated some success providing needed mental health care for veterans and their families. However, each needs more study before they can be expanded, exported or replicated, in order to determine their quality and efficacy on an objective basis. It may be possible for the VA to cultivate one or more of these models and inject public funding into one of these organizations to replicate their successes on a broader scale. However, even if the VA could establish an evidence base to support these models, such that it wanted to invest in them, the VA could not do so because it lacks an adequate legal framework for partnerships with the private or philanthropic sectors. In addition, mental health care provided through these philanthropic actors does not integrate into current VA health records or other systems, frustrating efforts to create continuity of care for veterans. For its part, the VA recognizes the need to leverage these partners more and has made establishing strategic partnerships a core objective in its 2014-2020 strategic plan.[25]

THE PRIVATE SECTOR

More veterans seek care outside the VA than within it. The median age of today's veterans population is 64. Consequently, nearly half of the veterans population qualifies by age for Medicare coverage. Among younger veterans, surveys indicate that more than 75 percent have private health insurance coverage. Recent research suggests that veterans choose the private sector for a collection of reasons, including convenience, economic efficiency, privacy and individual perceptions of efficacy or appropriateness.[26]

Given that most veterans seek their care (including care for service-connected ailments) from the private sector, the VA must also build mental health care capacity there as well. The VA should look for ways to build clinical and cultural competency in the private sector through programs such as personnel exchanges, training, continuing education, seminars, conferences and other activities. The VA should also explore the development of veteran-centric programs within private sector health organizations with a large volume of veterans, possibly with VA funding. Certain VA resources, such as the mobile Vet Centers, could also be expanded and deployed more to private sector hospitals and health campuses to provide complementary capability alongside private sector providers. And, as discussed more fully below, the VA should explore ways to create an IT environment that allows private sector and VA providers to share health information, in order to provide continuity of care regardless of where veterans obtain help.

Recommendations

DEVELOP AND SHARE DATA REGARDING VETERANS' MENTAL HEALTH CARE

Anecdotal evidence and provider surveys suggest that veterans have difficulty accessing VA mental health care. However, there is no publicly available data to confirm or deny this, nor to help veterans make decisions about care based on availability, wait times or other relevant data. Indeed, the Government Accountability Office has repeatedly cited the VA's inaccurate and unreliable estimates of patient demand and waiting times as a serious concern, and an impediment to improvement.[27] Consequently, the policy debate proceeds under potentially flawed assumptions regarding the demand for mental health care services in the veterans community. And, more pointedly, both veterans and veteran-serving organizations in the private and nonprofit sector struggle to make smart decisions in the absence of data.

The VA should make available data on the utilization of its mental health care resources, including wait time data for specific facilities.[28] This data should be made available in usable form for veterans, such as through geospatial information displays or through application interfaces like the VA's PTSD application for smartphones. Such data would better enable VA personnel to coordinate and allocate resources, facilitate the allocation of resources within the private sector that also serves veterans and improve decision making by veterans based on the availability of mental health care. Ideally, such a system would also link to the VA's scheduling system and give veterans a choice to schedule appointments from a range of nearby facilities and options (including contracted facilities and networks) based on projected availability and wait times. The VA should also integrate this system into its nascent Veterans Relationship Management system and leverage the data collected from its mental health care scheduling and interface systems to project future utilization trends so it can plan and allocate resources more smartly.

EMBRACE A PORTFOLIO APPROACH

Within the VA, a great deal of effort is being put toward internal growth, as well as to the procurement of additional care networks, such as the PCCC contracts awarded in September 2013. Although no one of these approaches offers a panacea, some offer more potential than others. The VA should develop a portfolio approach that adopts all of the models outlined above, investing most heavily in those approaches which have the potential for scalability, replicability and quality care. Over time, the VA should reinforce its successful programs, eliminate unsuccessful efforts and change its infrastructure to reflect the lessons learned through this evaluation.

The key to success will be a rigorous monitoring and evaluation regime that assesses each VA program on efficiency, efficacy and programmatic metrics. Ultimately, these metrics should be linked to outcomes for veterans, such as those relating to veteran wellness, not merely effort expended by the VA or outputs of VA efforts such as man-hours worked or appointments conducted.[29] Veterans organizations agree that the VA needs to do more to reinforce its success and eliminate nonperforming programs, so as to offer only the best care options to veterans. In their latest independent budget report, four leading veterans organizations wrote that "VA should establish pilot programs to improve continuity of care and retention of veterans in evidence-based PTSD treatment programs." During the past five years, the VA has developed a nascent program evaluation capability within its Office of Policy and Planning. To effectively execute a portfolio strategy in the mental health care space (and others), the VA must further develop this capability to the point where it can conduct program evaluations across the agency's portfolio of

care, in near real time, and provide feedback to VA health leaders at the regional and national level, as well as human resources, capital planning and procurement staff, to enable programmatic corrections based on performance.

DEVELOP A WRAPAROUND INFORMATION ENVIRONMENT FOR CARE

The great disadvantage of a portfolio approach is the lack of integration for some of the models that provide care to veterans outside of the VA. Clinicians have long seen the lack of "continuity of care" as an impediment – particularly where mental health care is disconnected from primary care or other services, and where prescriptions are not necessarily checked against one another in a common medical record. However, the goal of an integrated health records system, and accompanying appointments system and clinical information infrastructure, has also been the holy grail of the veterans health care arena for decades – long sought, at great cost, but never reached.

To date, the focus has been on a better system to integrate VA and DOD health records. Unfortunately, this falls short of the full requirement for the VA, which is a health information environment that integrates with the private sector and philanthropic sector as well, where veterans go for the majority of their health care (including mental health care). In some respects, the focus on integration with DOD has only frustrated and obscured the greater importance of a system that offers interoperability with the private sector. As part of its efforts to generate more mental health care capacity, and use a portfolio approach to doing so, the VA must also develop a comprehensive information environment that enables VA providers and partners in other sectors to communicate and share information. Such a system will improve care for veterans by providing better continuity across the range of public, private and philanthropic providers and also will give the VA better data regarding the population with which to allocate resources and make decisions about future agency operations.

DEVELOP AND LEVERAGE COMMUNITY COORDINATION STRATEGIES

In addition to these systems for operational coordination, the VA should continue its nascent efforts to engage community leadership structures in its efforts to serve veterans. VA Secretary Eric Shinseki directed this summer that all VA medical centers conduct community engagement summits before the end of the fiscal year, in order to engage and leverage the enormous number of private organizations serving veterans outside of the VA. These efforts should continue and be institutionalized through the creation of standing Citizens Advisory Committees at each VA medical center.[30] These committees should include representatives from the veterans community, industry, local government and private organizations serving veterans, in a manner tailored to the particular landscape of each community.

Additionally, the VA can capitalize on existing community-level coordination to operate more effectively at the local level. For example, King County, Wash., has made great strides in coordinating efforts at the county level. Leveraging investments from a modest county property tax levy (voted on by King County residents), it has been able to make strategic investments in mental health care capacity for veterans and their families (among other veterans issues). The county invested more than $500,000 in veteran PTSD and mental health treatment and $200,000 in regional service capacity building, appointing the Washington State Department of Veterans Affairs as lead agency in the efforts.[31] Within this system, the country has pursued a formal partnership with the VA Puget Sound Health Care System and other providers, playing a key role in coordinating resources

across the Seattle area, filling capacity gaps and ensuring that "consumers of community-based services continue to be integrated into the health care systems of the Department of Veterans Affairs."[32]

In its draft strategy for 2014-2020, the VA embraces the goal of improving relationships with other federal agencies, state and local governments, veterans and military service organizations, nonprofit organizations and private sector firms, among others. The VA goes so far as to say it "must develop a partnership culture that entails trust, transparency, mutual benefit, responsibility, productivity, and accountability" and that the VA will "pursue opportunities for partnering with organizations that can best provide what [the VA] cannot or should not."[33] However, the VA's strategy does not go nearly far enough, setting only modest goals for increasing the number of formal partnerships and increasing the numbers of states and cities included in the VA's databases. If the VA is to partner more meaningfully and effectively with the private and philanthropic sectors, it must embrace a broader vision of its partnership, where the VA is an equal partner with these other sectors. The VA strategy should include a multicomponent structure for engagement with non-VA actors, including policies that foster such partnership, and rules within VA's ethical and acquisition regulations that allow such partnerships to occur. The VA must also develop a governance and coordination structure, possibly by creating additional federal advisory committees, or local advisory committees in its health care regions or near its major medical centers. And the VA should invest in these community partnerships, using VA capital to fund the "best practice" organizations that are serving veterans in the philanthropic and private sectors, and arguably doing so as well as (or better than) the VA.

BUILD A HUMAN CAPITAL PIPELINE

Current efforts to add clinical staff at the VA have been hindered by a national shortage of qualified, available mental health care personnel. This lack of clinicians who have cultural competency in working with veterans and the military community has exacerbated the shortage, and made it very difficult for the VA to expand its workforce. The VA should address this by expanding its partnerships with academic medical programs to include additional programs that develop mental health care personnel. This expansion should build on the VA's extensive program for clinical internships. The human capital pipeline should also leverage existing relationships between the VA and programs producing clinical social workers and psychologists with specializations in military social work or related disciplines, such as those at the University of Southern California and University of South Carolina.[34] The VA should invest in these programs, expand them and seek to replicate them, particularly where they can help produce additional clinical personnel to serve underserved populations (such as in rural areas). The VA should also look for opportunities to integrate veterans into its human capital pipeline, ranging from work in Vet Centers and outpatient clinics to service in VA medical centers. In furtherance of this goal, the VA should study the feasibility of a national scholarship, apprenticeship or training program (possibly tied to existing VA educational benefits) that would generate its own pipeline of veterans with the training and desire to provide mental health care services to fellow veterans in VA facilities.

INVEST IN EMERGING TECHNOLOGIES

Emerging technologies hold enormous promise for the VA and its efforts to provide mental health care services to veterans. Telemedicine is the most mature of these technologies, with significant evidence to show its efficacy and support its expansion. This technology holds particular promise for expanding VA care in underserved communities (such as rural areas), and for serving the digital

natives of the millennial generation, for whom communication via Skype is as natural as participation in a Vet Center rap group was for the Vietnam War generation.

The VA should also invest in fitness monitoring and communications technologies that can expand the net of mental health care. These include hardware solutions such as the "FitBit," which monitors physical activity, sleep, weight and other behaviors, and software solutions such as the PTSD Coach, developed by the VA and fielded to more than 100,000 smartphone users.[35] Because connectivity and technology may pose barriers to entry for some veterans, the VA should consider investing in the provision of smartphones to veterans where it determines that the benefits of doing so outweigh the costs, and compare favorably to the costs of providing comparable care and services via existing VA brick and mortar facilities.

A third area for investment is virtual reality technology and its application for both the training of clinical personnel and the treatment of veterans. Enormous strides have been made in the use of simulations for training purposes, with the latest advances in avatar technology and artificial intelligence providing fully interactive, dynamic, unscripted computer-generated simulations that can replicate the clinical environment.[36] Extensive DOD funding has led to many of these advances, both for purposes of building combat simulations for military training purposes and for clinical purposes. These simulations can be used to generate mental health care capacity, through training of new clinicians and developing cultural competency among existing providers. In the future, such technologies could also mature to the point where they can be used for clinical treatment as well. With additional investment and development, virtual reality counseling sessions could be used to monitor veterans and provide other rote forms of clinical support. It is even possible to imagine counseling provided through virtual reality simulations that would go beyond this, such as counseling groups that would bring together veterans in a virtual environment to interact via avatars.

Conclusion

The VA will spend at least $7 billion this fiscal year on mental health to serve more than 1.3 million veterans.[37] As large as these dollar figures are, the VA still will not meet the needs of all veterans who need mental health care. Treatment clearly makes a difference for veterans suffering from the invisible wounds of war: those receiving treatment do better in managing their post-traumatic stress or traumatic brain injury and are less likely to commit suicide. The VA should use the approaches described above to expand and extend the net of mental health care it provides to veterans.

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ENDNOTES

1. Considerable debate exists over the proper terminology for describing veteran mental health issues. This paper uses "post-traumatic stress disorder" to describe those mental health issues that are diagnosed as PTSD under the applicable clinical guidelines, and "veterans' mental health issues" or other similar language to refer to the broader set of mental health concerns existing within the veterans population, which include but are not limited to PTSD.

2. Linda J. Bilmes, "The Financial Legacy of Iraq and Afghanistan: How Wartime Spending Decisions Will Constrain Future National Security Budgets," HKS Faculty Research Working Paper Series RWP13-006 (Harvard Kennedy School, March 2013).

3. See "The War Within: Treatment of Traumatic Brain Injury and Post Traumatic Stress Disorder, Findings and Recommendations" (The American Legion TBI/PTSD Ad Hoc Committee, September 2013), http://legion.org/documents/legion/pdf/american-legion-war-within.pdf.

4. In 1995, the VA reorganized the disparate field management structure of VHA, replacing "four regions, 22 networks, and 159 independent VA medical centers with 22 Veterans Integrated Service Networks (VISNs) that report directly to the Office of the Under Secretary for Health." There are currently 23 VISNs. The VISNs' "primary function was to be the basic budgetary and planning unit of the veterans' health care system." See Department of Veterans Affairs, *Health Policy Planning Vision*, Chapter. 2: *VHA Field Organization Report to Congress*, http://www.va.gov/HEALTHPOLICYPLANNING/VISION/3CHAP2.pdf; and VISN Reorganization Act of 2012, http://www.burr.senate.gov/public/_files/VISNAct.pdf.http://www.burr.senate.gov/public/_files/VISNAct.pdf.

5. Department of Veterans Affairs, *Selected Veterans Health Administration Characteristics, FY2002 to FY2012*, http://www.va.gov/vetdata/Utilization.asp.

6. Department of Defense Contingency Tracking System, *Profile of Service Members Ever Deployed* (July 31, 2013).

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